PRINTED: 08/09/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X3) OATE SURVEY STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA COMPLETEO IOENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILOING __ R-C B. WING 07/27/2016 495420 STREET AOORESS, CITY, STATE, ZIP COOE NAME OF PROVIDER OR SUPPLIER 1540 FOUNDERS PLACE ALBEMARLE HEALTH AND REHABILITATION CENTER CHARLOTTESVILLE, VA 22902 PROVIDER'S PLAN OF CORRECTION IX51 COMPLETION DATE SUMMARY STATEMENT OF OFFICIENCIES (X4) IO (EACH CORRECTIVE ACTION SHOULO BE PREFIX (EACH OFFICIENCY MUST BE PRECEOSO BY FULL PRÉFIX CROSS-REFERENCEO TO THE APPROPRIATE REGULATORY OR LSC IOENTIFYING INFORMATION) TAG TAG OEFICIENCY) The statements included are {F 000} {F 000} INITIAL COMMENTS not an admission and do not constitute agreement with the An unannounced Medicare/Medicaid follow-up alleged deficiencies herein. survey to the abbreviated Standard survey of The plan of correction is 06/07/2016 through 06/09/2016 was conducted on 07/26/2016 through 07/27/2016. Corrections completed in the compliance of are required for compliance with 42 CFR Part 483 state and federal regulations as Federal Long Term Care Requirements. outlined. To remain in Uncorrected deficiencies are identified within this compliance with all federal and report. Corrected deficiencies are identified on the CMS 2567-B. Two complaints were also state regulations the center has investigated during this survey. taken or will take the actions set forth in the following plan The census in this 120 certified bed facility was of correction. The following 87 at the time of the survey. The survey sample consisted of 10 current Resident reviews plan of correction constitutes (Residents #101 through #109 and Resident the center's allegation of #111) and one closed record review (Resident compliance. All alleged deficiencies cited have been or F 155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE F 155 SS=D ADVANCE DIRECTIVES will be completed by the dates indicated. The resident has the right to refuse treatment, to refuse to participate in experimental research, F 155 and to formulate an advance directive as specified in paragraph (8) of this section. 1. How corrective action The facility must comply with the requirements will be accomplished for each specified in subpart I of part 489 of this chapter resident found to have been related to maintaining written policies and procedures regarding advance directives. These affected by the deficient requirements include provisions to inform and practice: provide written information to all adult residents Patient #101 had a Durable Do concerning the right to accept or refuse medical Not Resuscitate Order (DNR) or surgical treatment and, at the individual's option, formulate an advance directive. This dated 05/10/08 on the medical includes a written description of the facility's record. A Physician Order was policies to implement advance directives and completed indicating Resident applicable State law. #101 was a DNR. LAPORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
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		495420 B. WING			07/27/2016
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
		SELLABULITATION OF NITED		1540 FOUNDERS PLACE	
ALBEMAR	LE HEALTH AND F	REHABILITATION CENTER		CHARLOTTESVILLE, VA 22902	
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F 155 Continued From page 1

F 155

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review the facility staff failed to formulate advance directives for one of 11 residents, Resident #101.

Resident #101's paper record contained a "Durable Do Not Resuscitate Order" (DNR) dated 05/10/2008. There were no orders on his current physician order sheet indicating that Resident #101 was a DNR.

Resident #101 was admitted to the facility on 02/19/2016. His diagnoses included but were not limited to: Dementia, ESRD (end stage renal disease), Type II diabetes mellitus, hypertension, heart failure, epilepsy, and chronic pain.

The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/16/2016. Resident #101 was assessed as having a difficulty with both long and short term memory as well as being severely impaired with daily decision making skills.

The electronic medical record (EMR) was reviewed on 07/26/2016. The POS (physician order sheet) was reviewed. Listed within the diagnoses for Resident #101 was "DO NOT RESUSCITATE". There was a diagnosis code listed beside the entry. The orders on the POS were reviewed there were no orders regarding code status listed within the orders. The care plan, the medication administration record, and

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- 2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:
 All current residents were audited for the presence of both the Durable Do Not Resuscitate Order and Physician Order for DNR. All
- 3. Measures to be put in place or systemic changes made to ensure practice will not recur:

remaining residents were in

compliance.

The Staff Development
Coordinator/designee will inservice all charge nurses on the policy and process of initiating the Advance Directive, entering the order into the electronic record, and obtaining a physician signature for each order.

4. How facility will monitor corrective action(s) to ensure deficient practice will not recur:

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F 155 Continued From page 2

the progress note sections were reviewed. There were no entries observed regarding the resuscitation status of Resident #101.

On 07/27/2016 the paper chart was reviewed. Observed within the paper chart was a "Durable Do Not Resuscitate Order" dated 05/10/2008. The form was signed by a physician and a representative for the resident.

The DON (director of nursing) was interviewed on 07/27/2016 regarding the location of a resident's resuscitation status in the clinical record. She stated that the resuscitation status should be on the "dashboard" in the electronic record. Resident #101's electronic record was reviewed. The DON pointed to an area at the top of the screen that contained information for the resident. The information included but was not limited to, the resident's picture, date of birth, physician, and allergies. No resuscitation status was listed. She pointed to the screen, underneath the allergies and stated, "It would be right here." She was asked if orders were needed regarding resuscitation status. She stated, "We need an order for a DNR." The DON was asked what the procedure would be if no resuscitation status was listed. She stated, "The would be a full code." The DON was told that a DNR form had been located in the paper record and that "DO NOT RESUSCITATE" was listed in the diagnosis section. She stated she would look into it.

A meeting was held on 08/27/2016 at approximately 9:30 a.m. with the DON, the administrator and the corporate nurse consultant. The above information was discussed. The DON and the corporate nurse consultant stated that if a resident were to code, the EMR would be where

F 155

Any deficient practice will result in re-education or disciplinary action as indicated. The Director of Nursing will report findings to the QA committee quarterly times three for revisions, tracking and trending

5. Completion date August 17, 2016

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Facility ID: VA0417 RECEIVED Continuation sheet Page 3 of 25

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NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	

ALBEMARLE HEALTH AND REHABILITATION CENTER

1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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F 155

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 279

practice:

Center.

1. How corrective action

will be accomplished for each

Resident #108 had an update of

the Care Plan in place for the

2. How corrective action

those residents having the

All current residents will be

comprehensive Care Plan has

been developed to include

potential to be affected by the

will be accomplished for

same deficient practice:

reviewed to ensure a

PICC line services.

PICC line to include all

services provided by the

resident found to have been

affected by the deficient

(X5) COMPLETION OATE

F 155 Continued From page 3

staff looked for code status, not the paper chart.

An end of survey meeting was held on 07/27/2016 at approximately 1:40 p.m. with the DON, the administrator and corporate staff. A new DNR form, signed and dated 07/27/2016 was presented. Per the corporate nurse consultant, Resident #101 had been a DNR at the previous facility where he resided. Upon transfer to his current facility the order for the DNR was overlooked and not written. Orders were written that day (07/27/2016) to implement the DNR status.

No further information was received prior to the exit conference on 07/27/2016.

{F 279} 483.20(d), 483.20(k)(1) DEVELOP SS=D COMPREHENSIVE CARE PLANS

(F 279)

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment

3. Measures to be put in place or systemic changes made to ensure practice will not re-occur:

The Staff Development Coordinator/designee will inservice charge nurses on the policy and procedure for Care Planning to include initiation and activation for a PICC line $\frac{1}{15}$ Care In-servicing will include developing an initial Care Plan on admission or when a PICC line is inserted during the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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{F 279} Continued From page 4 under §483.10(b)(4). {F 279}

This REQUIREMENT is not met as evidenced by:
Surveyor: HALL, YVONNE

Based on staff interview and clinical record review, facility staff failed to develop a comprehensive care plan (CCP) for one (1) of eleven (11) residents in the survey sample, Resident #108.

Facility staff failed to develop a CCP for care of a PICC (peripherally inserted central catheter) line for Resident #108.

Findings included:

Resident #108 was admitted to the facility on 07/05/2016 with diagnoses including, but not limited to: Right Ankle Fracture with ORIF (open reduction internal fixation), Bacterial Infection, Diabetes Mellitus, Sleep Apnea, Cellulitis, Cataracts, Hypertension and Depression.

The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 07/12/2016. Resident #108 was assessed as cognitively intact with a total cognitive score of 15 out of 15.

The electronic medical record (EMR) for Resident #108 was reviewed on 07/26/2016 at approximately 2:40 p.m. During the record review specific physician orders were noted for care of a PICC line. Per the current POS (physician order sheet) dated July 2016: "...PICC

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-

The Unit Manager/designee will review all new admissions for new orders on PICC lines five

times a week for four weeks, weekly times two weeks, monthly times one month then, quarterly times three quarters to identify residents with a PICC line.

Any deficient practice will result in re-education or disciplinary action as indicated. The Director of Nursing will report findings to the Quality Assurance Committee quarterly times for revision, tracking and trending.

5. Completion date August 17, 2016

Facility ID RECEIVED

If continuation sheet Page 5 of 25

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM.	08/09/2016 APPROVED 0938-0391
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(F 279)	weekly and PRN (a Solution Reconstitute gram intravenously until 07/27/2016 100 UNIT/ML (millil every 8 (eight) hou Saline Flush Solution Flush) Use 10 unit hours for sash (sali protocol" These noted on the MAR sheet). The CCP for this reregarding care of hereident receives Infection or inflammed dressing per MD (pother specific interection or inflammed of the survey team, A Consultant and Coregarding the CCP The DON stated, "interventions for castarted last Monda."	age 5 age upon admission and as needed)Cefazolin Sodium ated 1 (one) GM (gram) Use 2 a every 8 hours for infection deparin Lock Flush Solution liter) Use 10 unit intravenously as for heparin lockNormal on 0.9% (Sodium Chloride intravenously every 8 (eight) ine/antibiotic/saline/heparin) physician orders were also (medication administration desident included the following ater PICC line: "Focus: V (intravenous) abx CC in upper left arm Goal: for s/sx (signs/symptoms) of mation Interventions: change ohysician) order" (sic) No ventions were included on the desident #108's PICC line. of nursing) was interviewed on the desident #108's PICC line. I would expect specific are of the PICC line. I just by (meaning 07/18/2016)." tion was received prior to the		79}			
{F 281) SS=D	exit conference on	07/27/2016. RVICES PROVIDED MEET	{F	281}	RECEIVE		

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(F 281) Continued From page 6

The services provided or arranged by the facility must meet professional standards of quality.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility staff failed to follow professional standards of nursing for two of 11 residents, Resident #104 and Resident #103

- 1. Resident #104's 6:30 a.m. dosages of insulin were not administered on three different occasions based on fingerstick blood sugar readings. There were no parameters listed to determine when insulin dosages should not be given, nor was the physician notified of the nurse's decision to withhold the physician ordered insulin.
- 2. Resident #103 did not have physician ordered changes in her Parkinsonian Medications clarified and implemented until 14 days after the resident visited the neurologists office.

Findings were:

Resident #104 was admitted to the facility on 02/16/2016. His diagnoses included, but were not limited to Paraplegia, Type 2 Diabetes Mellitus, hypertension, heart failure, glaucoma and neurogenic bladder.

The most recent MDS {minimum data set} was a quarterly assessment with an ARD (assessment reference date) of 05/05/2016. Resident #104 was assessed as having a cognitive summary score of "15", indicating no impairment with his cognitive status.

{F 281}

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F 281

1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice:

Resident #104 had parameters ordered by the physician to determine when the insulin dosages should not be given and when to notify the physician with any deviation from the order.

Resident #103 received clarification and implementation on the order change for the Parkinsonian Medications.

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:
All the current residents were reviewed to identify potential consult order changes that failed to meet and/or follow

consult order changes that failed to meet and/or follow professional standards of nursing practice or departed from appropriate care such as:

)f continuation sheet Page 7 of 25

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		**********	•	RINTED: 08/09/2016 FORM APPROVED
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		495420	B. WING			07/27/2016
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
ALBEMA	RLE HEALTH AND R	EHABILITATION CENTER			540 FOUNDERS PLACE HARLOTTESVILLE, VA 22902	
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(F 204)	Cartinued Erom po	200 7	{F 2	281)		lowing physician
(F 281)	Continued From pa	ige i	11 ∠	-017		ders
	The electronic med	lical record (EMR) was				mmunicating order
	reviewed on 07/26/	2016. The POS (physician				anges to the
	order sheet was re	viewed). Orders listed			•	ysician
	included but were i	not limited to: "Accuchecks by related to TYPE 2				Ihering to Center
	DIARFTES MELLI	TUS, MetFORMIN HCL				licy and procedure
	Tablet 500 mg Give	e 1 tablet by mouth two times a			4. Do	ocumentation of
	day related to TYP	E 2 DIABETES MELLITUS;			th	e appropriate
	NovoLOG Mix 70/3	30 Suspension (70-30) 100Inject 30 unit subcutaneously			in	formation in the
	in the morning rela	ted to TYPE 2 DIABETES			m	edical record
	MELLITUS; Nov	oLOG Mix 70/30 Suspension			5. A	dministering
	(70-30) 100 UNIT/	MLInject 32 unit				nedications as
	DIABETES MELLI	the evening related to TYPE 2 TUS; NovoLOG Solution 100	ı			rdered.
	UNIT/MLInject 5	unit with meals related to			A 11 : I - mtifica	d areas of non-
l	TYPE 2 DIABETE	S MELLITUS" There were rameters or guidelines ordered			All identified	u alcas of non
-	for withholding ins	ulin.			compliance	will result in re-
	_				education of	f the involved
	The MAR (medica	tion administration record) was			nurse.	
	then reviewed. Re	esident #104's morning dosage IG Mix 70/30 Suspension				
	(70-30) 100 UNIT	MLInject 30 unit				
	subcutaneously in	the morning related to TYPE 2			3. Measur	es to be put in
	DIABETES MELL	(TUS) was scheduled to be				stemic changes
	given at 6:30 a.m.	The dosage of insulin			made to en	sure practice will
<u> </u>	scheduled to be g	iven with meals (NovoLOG /MLInject 5 unit with meals			not re-occu	
ļ	related to TYPE 2	DIABETES MELLITUS) was				evelopment
1	scheduled for 6:30) a.m., 12:15 p.m., and 5:30				r/designee will in-
1	n.m. The twice a	day Accuchecks were				ses on providing
	scheduled for 6:30	0 a.m. and 4:30 p.m.				at meet professional
}	The documentation	on on the MAR for both morning				f nursing practice
	doses of Novolog	insulin (30 units of Novolog				does not depart
	70/30 and 5 units	of Navolag Solution) on				
	07/20/2016, 07/22	2/2016 and 07/23/2016 was "5"			irom appro	priate care such as:

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from appropriate care such as:

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ALBEMA	RLE HEALTH AND R	EHABILITATION CEN	ITER		CH/	ARLOTTESVILLE, VA			
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							1.		Following
(F 281)	Continued From pa	age 8		{F 28	31}			phy	sician orders
(1 201)	and a nurse's initial	_	ne MAR		,		2	. ,	nmunicating order
	was reviewed. The	chart code listed for	r "5" was:				۷.		
	"Hold/See Progress								nges to the
	_	•						phy	sician
	The progress note	section was then re	viewed.				3.	Adh	ering to Center
	The following entries	es were observed:						poli	cy and procedure
	"07/20/2016 NovoL	∩G Mi∨ 70/30 100 I	INIT/MI				4.	Dod	umentation of
	Inject 30 unit subcu								appropriate
	related to TYPE 2 [DIABETES							rmation in the
	MELLITUSsched	uled Novolog 70/30	mix insulin						:
	was held d/t [due to	o] FSBS [fingerstick	blood						tronic medical
	sugar - Accucheck	s] at 160 at 0620 [6:	20 a.m.]"					reco	ord
		regarding why the					5.	Adn	ninistering 🔝
	dosage of Novolog	5 units, was not giv	C11.					med	dications as
	"07/22/2016 Novol	log Solution 100 UN	IT/ML					ord	ered.
	Inject 5 unit subcut	aneously with meal:	s related to						
		S MELLITUSSche	duled	-					
	Novolog held d/t FS	SBS at 170"							
	1107/00/0046 Novel	LOG Mix 70/30 100	L1N117/8/II			4.	How fa	cilit	y will monitor
		itaneously in the mo							on(s) to ensure
	related to TYPE 2.		orrining.			COL	CCCITC	ucti	on(s) to clisure
		luled Novolog 70/30	insulin			def	icient p	ract	ice will not re-
	held d/t FSBS at 17					eur	:		
						The	Direct	or of	;
		log Solution 100 UN							ee will review
	Inject 5 unit subcut	aneously with meal MELLITUSSche	s related to				_	_	ort and new
	Novolog held d/t FS		adiea					-	
İ	Movelog Hold divi	0D0 at 101							es a week for
	"07/23/2016 Novo	LOG Mix 70/30 100	UNIT/ML					-	ekly times two
	Inject 30 unit subcu	utaneously in the mo						_	times one month
	related to TYPE 2		. (t.) -1 <i>1</i> 6					-	times three to
		luled Novolog 70/30	neia a/t			ide	ntify an	y dej	parture from
	FSBS at 167."					app	ropriate	e car	e relating to
	There was no docu	umentation in the pr	ogress note)			owing 1		•
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{F 281} Continued From	om page 9	{F 2		Manager/des	

section that the physician had been notified of the nurse's decision to withhold regularly scheduled morning doses of insulin based on the morning Accuchecks readings.

On 07/26/2016 the unit manager, RN (registered nurse) #1 and the DON (director of nursing) were interviewed regarding the nurse's decision to withhold the morning doses of insulin on three separate occasions for Resident #104. They were asked if there were standing orders or a policy regarding when insulin should be held based on Accuchecks readings. The DON stated, "We should have parameters written...if not we should have notified the physician." The DON was asked if she would have held insulin based on the blood sugar readings listed in the progress notes. She stated, "No, not for that...usually you have parameters like greater than 400 or less than 60 to call the doctor..." The unit manager stated, "We don't have standing orders to hold insulin." The DON also stated, "We will talk to the nurse tonight and find out what happened." The DON was asked if the physician had been notified would she expect to see documentation indicating that. She stated, "Yes."

On page 419, Fundamentals of Nursing Potter and Perry, Chapter 22, Legal Implications of Nursing Practice, "Physicians' Orders: The physician is responsible for directing medical treatment. Nurses are obligated to follow physicians' orders unless they believe the orders are in error or would harm the clients. Therefore all orders must be assessed, and if one is found to be erroneous or harmful, further clarification from the physician is necessary....In a malpractice lawsuit against a physician and a hospital one of the most frequently litigated

orders and physician communication or clarification of those orders and for any omission of documentation on the eMAR (electronic medication administration record) with proper notification to the physician of that omission.

Any deficient practice will result in re-education or disciplinary action as indicated. The Director of Nursing will report findings to the Quality Assurance Committee quarterly times three for Revision, tracking and trending.

5. Completion date August 17, 2016

> RECEIVED AUG 16 2016 VDH/OLC

PRINTED: 08/09/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING __ R-C 07/27/2016 B. WING 495420 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1540 FOUNDERS PLACE ALBEMARLE HEALTH AND REHABILITATION CENTER CHARLOTTESVILLE, VA 22902 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID COMPLETION OATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFF IX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {F 281} {F 281} Continued From page 10 issues is whether the nurse kept the physician informed of the client's condition..." (1) On 07/27/2016 a meeting was held at approximately 1:40 p.m., with the DON, the unit manager, the administrator and the corporate staff present at the facility. The above information was discussed. The unit manager stated that they had tried to reach the nurse who had held the insulin but she was not answering her phone and had not shown up for work on 07/26/2016. The unit manager stated, "I contacted [name of physician] about the insulin not being given on those dates. He said that he would have agreed with the nurse's decision to not give the insulin." She presented a note that she had written at 8:37 a.m. which read: "7/27/2016 08:37 Communication with Iname of physician] revealed that [name of physician] would have agreed with the nurse on 7/19, 7/20, 7/22 and 7/23 to hold insulin due to blood sugar

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No further information was obtained prior to the exit conference on 07/27/2016.

results and the fact that resident would not be having breakfast until after 0800. [Name of physician] informed writer that his main concern for this resident is hypoglycemia. [Name of physician] has changed the 0630 order time for accuchecks and insulin administration to 0800."

The DON was asked how long the facility staff had to notify the physician that an order such as insulin had been omitted. The corporate nurse consultant stated, "It should be within 24 hours,

but for insulin it should have been at the time it

(1) Potter, Perry. Fundamentals of Nursing

happened."

Facility ID: VA0417

VDH/OLC

PRINTED: 08/09/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMEN FOF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION R-C 07/27/2016 B WING 495420 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1540 FOUNDERS PLACE ALBEMARLE HEALTH AND REHABILITATION CENTER CHARLOTTESVILLE, VA 22902 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (X4) ID **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG {F 281} {F 281} Continued From page 11 Practice, 6th Edition. Mosby. St. Louis, Missouri. 2005. 2. Resident #103 did not have physician ordered changes in her Parkinsonian Medications clarified and implemented until 14 days after the resident visited the neurologists office. Findings were: Resident #103 was admitted to the facility on 03/19/2016. Her diagnoses included but were not limited to: Parkinson's disease, anxiety, depression, and hypertension. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 06/25/2016. Resident t#103 was assessed as having a cognitive summary score of "15", indicating she was cognitively intact. Initial tour of the facility was conducted on 07/26/2016. Resident #103 was observed sitting in her room. She was asked how she was feeling. She stated, "Not too good, I am having an allergic reaction to some of my medications that they changed." A staff member in the room immediately left and returned within one to two minutes and stated, "I just asked the nurse, she said her medications are fine and there is no RECEIVED reaction." The electronic medical record was reviewed on AUG 16 2016 07/27/2016. The POS (physician order sheet)

contained the following orders:

"Carbidopa-Levodopa Tablet 25-100 mg

day related to PARKINSON'S DISEASE.

[milligrams] Give 1 tablet by mouth five times per

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/09/2016 FORM APPROVED

CENTERS FOR MEDICA	ARE & MEDICAID SERVICES			OMB NO. 0938-0391
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1	495420	B. WING		07/27/2016
NAME OF PROVIOER OR SUPPL	LIER		STREET AOORESS, CITY, STATE, ZIP COOE	
ALBEMARLE HEALTH AN	ID REHABILITATION CENTER		1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902	
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{F 281} Continued From page 12

Administer with Sinemet @ [at] 0700, 1200, & 1430 [2;30 p.m.]" The order date and the start date for that medication was 07/25/2016. Also observed was: "Sinemet CR Tablet Extended Release 25-100 mg (Carbidopa-Levodopa ER [extended release]] Give 1 tablet by mouth three times a day related to PARKINSON'S DISEASE Administer with Levodopa 25/100 at 0700, 1200, 1430 doses. The order date for this medication was 07/25/2016 and the start date was 07/26/2016.

The progress note section was reviewed. A note dated 07/24/2016 was observed which read, "Resident attended appt [appointment] with [name of hospital] Neurology on 07/12/2016 with [name of physician] with orders to start sinemet 25/200 one tab at **07**00, 0930, 1200, 1430, 1700. 1930 and sinemet CR 25/200 to be administered with the regular 25/100 at 0700, 1200, and 1700 times, RP [responsible party] is aware."

LPN (licensed practical nurse) #2 was interviewed on 07/27/2016 at approximately 8:30 a.m. regarding Resident #103's medications. She stated, "I wrote that note...I found her consult from the neurology clinic in a folder at the desk...the times on the consult sheet and the orders they sent didn't match so we had to get clarification...! saw that we hadn't done that yet, so I called them." LPN #2 was asked if she had gotten the clarification. She stated, "Yes, I guess I just pushed a little harder to get it."

A meeting was held on 07/27/2016 at approximately 9:00 a.m., with the DON (director of nursing), the administrator and the corporate nurse consultant. The above information was discussed. The DON stated that calls had been {F 281}

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Facility IO: VA0417

PRINTED: 08/09/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R-C 495420 B. WING 07/27/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1540 FOUNDERS PLACE ALBEMARLE HEALTH AND REHABILITATION CENTER CHARLOTTESVILLE, VA 22902 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES [X5] COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY {F 281} Continued From page 13 {F 281} made to the neurology clinic for order clarification but nothing had been documented. She stated that a fax was eventually sent in an attempt to get orders clarified. The DON was asked what the expected time frame for follow up on order clarification should be. She stated, "We should follow up as soon as possible." The DON was asked if she felt that the 13-14 day time frame for the implementation of the changes recommended by the neurology clinic was acceptable. She shook her head side to side indicating, "No." The DON was asked if the attempts to clarify the medication should have been documented. She stated, "Yes." The Lippincott Manual of Nursing Practice 10th edition states on page 16 regarding standards of nursing care, "A deviation from the protocol should be documented in the patient 's chart with clear, concise statements of the nurse's decision, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events. " {1) No further information was obtained prior to the exit conference on 07/27/2016.

{F 309} 483.25 PROVIDE CARE/SERVICES FOR SS=E HIGHEST WELL BEING

Each resident must receive and the facility must provide the necessary care and services to attain

(1) Nettina, Sandra M. Lippincott Manual of

Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

(F 309) AUG 1 6 2016

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PRINTED: 08/09/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING	(X3) OATE SURVEY COMPLETEO
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NAME OF PROVIOER OR SUPPLIER

ALBEMARLE HEALTH AND REHABILITATION CENTER

STREET AOORESS, CITY, STATE, ZIP COO

1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(X4) IO PREFIX TAG SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION) IO PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY) IX51 COMPLETION DATE

(F 309) Continued From page 14

or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, facility staff failed to follow physician orders for two of 11 residents in the survey sample, Resident #106 and Resident #104.

- 1. Facility staff failed to check fingerstick blood sugars (FSBS) per physician order for Resident #106.
- 2. Residen! #104's 6:30 a.m. physician ordered insulin dosages were not administered on three different occasions based on fingerstick blood sugar readings. On 07/26/2016 the medication nurse did not perform the accucheck or administer the physician ordered insulin.

Findings included:

1. Facility staff failed to check fingerstick blood sugars (FSBS) per physician order for Resident #106.

Resident #106 was admitted to the facility on 06/15/2016 with diagnoses including, but not limited to: Right Hip Fracture with ORIF (open reduction internal fixation), Diabetes Mellitus, Dementia without Behaviors, Atherosclerotic Heart Disease, hypertension, Depression, Sleep Apnea and Infection.

F 309

1. How corrective action will be accomplished for each resident found to have been affected by the deficient practice:

Resident #106 Accucheck order for AC and HS was discontinued when MD contacted. Nurse responsible for inputting order has been re-educated.

Resident # 104 Blood sugar checks was changed from 6:30 AM to 8 AM. MD notified of insulin being held with no new orders received. Parameters were placed on diabetics with routine Blood Sugars. Nurse that held insulin was reeducation

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:

Residents with finger stick blood sugars have been audited to ensure orders were completed appropriately with area to document blood sugars on the MAR (Medication administration Record).

FORM CMS-2567(02-99) Previous Versions Obsolele

Event **2 E V a** il y IO: VA0417

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PRINTED: 08/09/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495420	(X2) MUI A. BUILC B. WING		(X3) DATE SURVEY COMPLETEO R-C 07/27/2016
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ALBEMARLE HEALTH AND REHABILITATION CENTER

SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

CHARLOTTESVILLE, VA 22902

(X5) COMPLETION DATE

(F 309) Continued From page 15

(X4) ID

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The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 06/22/2016. Resident #106 was assessed as moderately impaired in her cognitive status with a total cognitive score of 08 out of 15.

The EMR (electronic medical record) of Resident #106 was reviewed on 07/26/2016 at 4:30 p.m. The current POS (physician order sheet) dated July 2016 included the following: "...Accuchecks AC (before meals) and HS (bedtime). Review of flow sheets in the EMR revealed blood sugar results completely blank. Review of the MAR (medication administration sheet) revealed no documentation of any blood sugar checks. This calculated out to 33 missed opportunities for blood sugar checks.

LPN #1 (licensed practical nurse) was interviewed on 07/27/2016 at 9:15 a.m. regarding blood sugar checks for Resident #106. LPN #1 pulled up the MAR for Resident #106 on the medication cart computer and stated, "It isn't on my MAR to check. Let's look at the orders." LPN #1 then pulled up physician orders for Resident #106. The orders revealed an order for Accuchecks AC and HS. LPN #1 stated, "Here is the order. It should be on the MAR." LPN #1 then pulled up the MAR for the previous 11-7 shift. No blood sugar check results were entered. LPN #1 stated, "I will get it today for sure and figure out why it isn't on the MAR. Should be checked AC and HS."

At approximately 10:00 a.m., during a meeting with the survey team, Administrator, DON (director of nursing), Regional Nurse Consultant RECEIVED and Corporate Representative, the above

(F 309)

Residents with orders for routine blood sugars have parameters added directing nurses when to call MD (medical doctor).. All professional staff have been reeducated on inputting orders into the medical record appropriately and parameters for blood sugars, holding insulin, and when to call MD. Order listing report will be checked the next business day to ensure new orders are captured.

3. Measures to be put in place or systemic changes made to ensure practice will not recur:

The Staff Development Coordinator/designee inserviced all nurses on correct order entry format in Point Click Care. The DON/Unit Manager/ designee will audit blood sugars and insulin orders of new resident five times a week for four week, weekly times two weeks, monthly times one week, then quarterly times three quarters on new admissions for accurate order entry format and documentation of blood sugars as ordered.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: VA0417 Event ID: XD6112

PRINTED: 08/09/2016 FORM APPROVED OMB NO. 0938-0391

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ALBEMARLE HEALTH AND REHABILITATION CENTER					OUNDERS PLA LOTTESVILL				
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The Regional Nu like the order was the computer sys transcription erro		ayed to facility administration. Consultant stated, "It sounds ot put in correctly." (Meaning m) The DON stated, "A	{F 3	09}		4. Homonitor ensure do not recurrent fin Assurance times three	corrected correc	Nursingto the Quantitee of	tion(s) to ice will g will quality quarterly
	insulin dosages wer different occasions sugar readings. Or nurse did not perfor	6:30 a.m. physician ordered re not administered on three based on fingerstick blood 07/26/2016 the medication m the Accuchecks or ician ordered insulin.				tracking a 5. Comp 2016	and tre	nding.	
	Findings were:								
	Resident #104 was admitted to the facility on 02/16/2016. His diagnoses included, but were not limited to Paraplegia, Type 2 Diabetes Mellitus, hypertension, heart failure, glaucoma and neurogenic bladder.								
	quarterly assessme reference date) of 0 was assessed as ha	DS (minimum data set) was a nt with an ARD (assessment 5/05/2016. Resident #104 aving a cognitive summary ating no impairment with his							
3	reviewed on 07/26/2 order sheet was rev	ical record (EMR) was 2016. The POS (physician riewed). Orders listed ot limited to: "Accuchecks r related to TYPE 2		F	RECEIV AUG 16 20	'ED			•

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STATEMENT OF DEFICIENCIES	
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AND PLAN OF CORRECTION	

(X1) PROVIDER/SUPPLIER/CLIA

495420

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

(X3) DATE SURVEY COMPLETED

07/27/2016

B. WING

R-C

NAME OF PROVIDER OR SUPPLIER

ALBEMARLE HEALTH AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

1540 FOUNDERS PLACE

CHARLOTTESVILLE, VA 22902

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

{F 309} Continued From page 17

DIABETES MELLITUS..., MetFORMIN HCL Tablet 500 mg Give 1 tablet by mouth two times a day related to TYPE 2 DIABETES MELLITUS..., NovoLOG Mix 70/30 Suspension (70-30) 100 UNIT/ML [milliliter]...Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS...; NovoLOG Mix 70/30 Suspension (70-30) 100 UNIT/ML...Inject 32 unit subcutaneously in the evening related to TYPE 2 DIABETES MELLITUS...; NovoLOG Solution 100 UNIT/ML...Inject 5 unit with meals related to TYPE 2 DIABETES MELLITUS...; There were no blood sugar parameters or guidelines ordered for withholding insulin.

The MAR (medication administration record) was then reviewed. Resident #104's morning dosage of insulin (NovoLOG Mix 70/30 Suspension (70-30) 100 UNIT/ML...Inject 30 unit subcutaneously in the morning related to TYPE 2 DIABETES MELLITUS) was scheduled to be given at 6:30 a.m. The dosage of insulin scheduled to be given with meals (NovoLOG Solution 100 UNIT/ML...Inject 5 unit with meals related to TYPE 2 DIABETES MELLITUS) was scheduled for 6:30 a.m., 12:15 p.m., and 5:30 p.m. The twice a day Accuchecks were scheduled for 6:30 a.m. and 4:30 p.m.

The documentation on the MAR for both morning doses of Novolog insulin (30 units of Novolog 70/30 and 5 units of Novolog Solution) on 07/20/2016, 07/22/2016 and 07/23/2016 was "5" and a nurse's initials. The coding for the MAR was reviewed. The chart code listed for "5" was: "Hold/See Progress Notes". The area for documentation on 07/26/2016 was blank for both morning doses of insulin and the morning Accuchecks.

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	0: 08/09/2016 MAPPROVED 0: 0938-0391	
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{F 309}	Continued From pa	age 18	{F 3	309}				
	The progress note The following entri	section was then reviewed. es were observed:						
	Inject 30 unit subcrelated to TYPE 2 MELLITUSsched was held d/t [due to sugar - Accucheck There was no note	LOG Mix 70/30 100 UNIT/ML utaneously in the morning DIABETES duled Novolog 70/30 mix insulin of FSBS [fingerstick blood is] at 160 at 0620 [6:20 a.m.]" is regarding why the 6:30 a.m. is 5 units, was not given.						
	Iniect 5 unit subcu	olog Solution 100 UNIT/ML taneously with meals related to S MELLITUSScheduled SBS at 170"					÷	
	Inject 30 unit subc	duled Novolog 70/30 insulin					·	
	Inject 5 unit subcu	olog Solution 100 UNIT/ML Itaneously with meals related to S MELLITUSScheduled SBS at 167"						
	Inject 30 unit subcretated to TYPE 2	oLOG Mix 70/30 100 UNIT/ML cutaneously in the morning DIABETES duled Novolog 70/30 held d/t						
	section that the pl	cumentation in the progress not nysician had been notified of the o withhold regularly scheduled insulin based on the morning	e e		RECEI			

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PRINTED: 08/09/2016 FORM APPROVED OMB NO. 0938-0391

> COMPLETION DATE

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE

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CENTERS FOR MEDICARE	E & MEDICAID SERVICES		OMB NO. 0938-039	
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
				R-C
	495420 ,			07/27/2016
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE		
ALBEMARLE HEALTH AND R	REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902		

{F 309} Continued From page 19 Accuchecks readings.

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{F 309}

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On 07/26/2016 the unit manager, RN {registered nurse) #1 and the DON (director of nursing) were interviewed regarding the nurse's decision to withhold the morning doses of insulin on three separate occasions for Resident #104. They were asked if there were standing orders or a policy regarding when insulin should be held based on Accuchecks readings. The DON stated, "We should have parameters written...if not we should have notified the physician." The DON was asked if she would have held insulin based on the blood sugar readings listed in the progress notes. She stated, "No, not for that...usually you have parameters like greater than 400 or less than 60 to call the doctor ... " The unit manager stated, "We don't have standing orders to hold insulin." The DON also stated, "We will talk to the nurse tonight and find out what happened." The DON was asked if the physician had been notified would she expect to see documentation indicating that. She stated, "Yes."

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

On 07/27/2016 a meeting was held with the DON, the unit manager, the administrator and the corporate staff present at the facility. The above information was discussed. The unit manager stated that they had tried to reach the nurse who had held the insulin but she was not answering her phone and had not shown up for work on 07/26/2016. The unit manager also stated, "I was working night shift and should have done the accuchecks and given the insulin yesterday (07/26/2016) morning...I was on the medication cart at 5:00 a.m...the computer turns the medication yellow on the screen when it is due, pink if it is overdue and if nothing is due it is white. When I signed off the cart everything was

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PRINTED: 08/09/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) OATE SURVEY (X1) PROVIOER/SUPPLIER/CLIA STATEMENT OF OFFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETEO IOENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILOING _ R-C B. WING 495420 07/27/2016 STREET AOORESS, CITY, STATE, ZIP COOE NAME OF PROVIOER OR SUPPLIER 1540 FOUNDERS PLACE ALBEMARLE HEALTH AND REHABILITATION CENTER CHARLOTTESVILLE, VA 22902 SUMMARY STATEMENT OF OFFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) iO (X4) IO PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULO BE PREFIX OATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCEO TO THE APPROPRIATE TAG TAG DEFICIENCY) {F 309} {F 309} Continued From page 20 white, meaning nothing was due....l changed carts and when the dayshift nurse came on the previous shifts medications don't show up...lt's my fault that he didn't get his Accuchecks or his insulin yesterday morning...l let the physician know last night that I missed it and I wrote a note." In regard to the omission of the insulin on the other dates in question she stated, "I contacted [name of physician] about the insulin not being given on those dates. He said that he would have agreed with the nurse's decision to not give the insulin." She presented a note that she had written at 8:37 a.m. which read: "7/27/2016 08:37 Communication with [name of physician] revealed that [name of physician] would have agreed with the nurse on 7/19. 7/20, 7/22 and 7/23 to hold insulin due to blood sugar results and the fact that resident would not be having breakfast until after 0800. [Name of physician] informed writer that his main concern for this resident is hypoglycemia. [Name of physician] has changed the 0630 order time for accuchecks and insulin administration to 0800." 1. How corrective action No further information was obtained prior to the will be accomplished for each exit conference on 07/27/2016. resident found to have been (F 431) 483.60(b), (d), (e) DRUG RECORDS, (F 431) SS=E LABEL/STORE DRUGS & BIOLOGICALS affected by the deficient practice: The facility must employ or obtain the services of Maintenance repaired the lock a licensed pharmacist who establishes a system on the 400 unit refrigerator of records of receipt and disposition of all controlled drugs in sufficient detail to enable an RECEIVED I units and carts were accurate reconciliation; and determines that drug records are in order and that an account of all

immediately checked for

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reconciled.

controlled drugs is maintained and periodically

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495420	B. WING		1	R-C 7/27/2016
NAME OF PROVIDER OR SUPPLIER ALBEMARLE HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
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Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily delected.

This REQUIREMENT is not met as evidenced by:

Based on observation and staff interview, the facility staff failed to ensure that medications were properly stored in three of three medication rooms currently in use at the facility.

Medication rooms located on the 100, 200 and 400 hall contained unlabeled medications, expired medications and medicaitons that were not in a separately locked, permanently affixed compartment.

Findings were:

{F 431}

medications. Any medications found out of compliance were discarded

2. How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice:

Pharmacy services audited all

units and carts for unsecured narcotics, expired medications, and undated open medications. Any medications out of compliance were discarded.

3. Measures to be put in place or systemic changes made to ensure practice will not recur:

The Staff Development Coordinator/designee inserviced all nurses on the Center policy and procedure for dating of medications, securing of medications, and discarding of expired or discontinued medications.

4. How facility will monitor corrective action(s) to ensure deficient practice will not re-cur:

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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XD6112

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The medication rooms at the facility were inspected on 07/27/2016 beginning at approximately 1:00 p.m.

The medication room on the 100 unit was observed. Contained in the refrigerator was an opened vial of PPD (tuberculin test solution). The vial was dated 05/28/2016. The DON (director of nursing) was in the room with this surveyor. The DON was asked if the date indicated the date the vial was open or the date it was to be disposed of. She stated, "I would think the date opened." The DON was asked how long the vial could be used after being opened. She stated, "I would think until the manufacturer's expiration date." Also contained in the refrigerator was an unopened bottle of Nystatin which had a pharmacy expiration date of 07/20/2016. The DON was asked if the resident who the medication was prescribed for was still at the facility. She stated, "Yes."

The medication room on the 400 unit was then inspected. Observed in the refrigerator was a bottle of liquid Omeprazole which expired on 07/22/2016. The resident the medication was prescribed for was still at the facility.

The medication room on the 200 unit was then inspected. An opened bottle of flu vaccine was observed. There was no date on the vial. LPN (licensed practical nurse) #1 stated, "I will throw that away...we haven't given those vaccines since the end of March." Also observed in the refrigerator was a "Hospice Kit." The resident listed on the kit was no linger residing in the facility. Contained in the kit was one 15 ml (milliliter) bottle of morphine and 10 tablets of .5

(F 431)

The Unit Manager/designee will audit each unit Medication Room and medication carts five times weekly for four weeks, weekly for two weeks, monthly for one month, then quarterly times 3 to identify and ensure narcotics are secure, expired medications are discarded, and all medications are dated when opened. Any deficient practice will result in re-education or disciplinary action as indicated. The Director of Nursing will report findings to the Quality Assurance Committee quarterly times three for revision, tracking and trending

5. Completion date August 17, 2016

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mg (milligram) Lorazepam. The kit was laying on a shelf in the refrigerator. The refrigerator did not have a lock. LPN #1 stated, "I don't know why they didn't put that in the locked box."

During an end of the day meeting on 07/27/2016 at approximately 1:40 p.m., the above information was discussed with the DON, the corporate nurse consultant and the administrator. The DON stated, "The TB test should be thrown away after 28 days." The administrator stated that the unit manager and the night shift nurses were suppose to check the medication rooms.

A copy of the manufacturer's insert for the PPD testing solution was requested from the DON, but not received. According to an online search for the manufacturer's instructions and package insert, the following information was found: PACKAGE INSERT TUBERSOL® Tuberculin Purified Protein Derivative (Mantoux)

STORAGE

Store at 2_ to 8_C (35_ to 46_F). DO NOT FREEZE. Discard product if exposed to freezing. Tuberculin PPD solutions can be adversely affected by exposure to light. The product should be stored in the dark except when doses are actually being withdrawn from the vial. A vial of TUBERSOL® [Tuberculin Purified Protein Derivative (Mantoux)] which has been entered and in use for 30 days should be discarded because oxidation and degradation may have reduced the potency. Failure to store and handle TUBERSOL® as recommended will result in a loss of potency and inaccurate test results. Do not use after expiration date. (1)

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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1
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	(1) https://www.vadoc_id=13693&ima	ccineshoppe.com/image.cfm? age_type=product_pdf				
	No further informat exit conference on	ion was obtained prior to the 07/27/2016.				
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